Meaningful Use Workgroup
Draft Transcript
February 12, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to a call of the Meaningful Use Workgroup. Just a reminder, the public is on the line, and there will be an opportunity at the end of this call for the public to make comment. Workgroup members, if you can please remember to identify yourselves when speaking and I'll do a roll call now. Paul Tang?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates? Christine Bechtel?

Eva Powell – National Partnership for Women & Families – Director IT
This is Eva Powell on the line for her.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Thanks, Eva. Neil Calman?

Neil Calman - Institute for Family Health - President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw?

Deven McGraw - Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charlene Underwood?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Micky Tripathi? Laura Gange? Karen Trudel or Tony Trenkle from CMS? Farzad Mostashari? Linda Fischetti? I'm on the line. Josh Seidman is on the line from ONC. Anybody else that I didn't call?

Art Davidson - Public Health Informatics at Denver Public Health – Director
This is Art Davidson.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson. Great. Okay. With that, I'll turn it over Paul and George.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you. This is our final call before the meeting next week for the policy committee that'll generate the final feedback, and we'll turn that around into a letter that needs to get presented to ONC. I guess, directly to CMS since that's the agency that published the NPRM, for our response to the NPRM.

I thought what we'd do is since we have no more time to run out of time to go over the things, two things. One is our homework assignment from last call, and the other are some of the topics we did, sort of clarification questions that we didn't get to, and them come back and review the letter that sort of is intended to reflect the conversations we've already had. Is that acceptable to folks?

M
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Starting with one of our homework assignments was the reminders and the measure for reminders to patients for patient preference. Originally, I was hoping that people would send in some written material to react to. I threw in an example. This is page 6/7 on the draft letter. And I can go over the way I phrased this possibility, and we can discuss it any other proposals.

The objective was to send reminders to patients per patient preference for preventative/followup care. The reason we had originally intended to put in the per patient preference is, although we wanted to make available electronic reminders, a patient may want it on paper, for example, and we wouldn't want to exclude that.

The measure draft that I wrote up is, so for a chosen preventative health service or followup, so that would give EPs the chance to decide what's relevant to them. For a chosen preventative health service or followup that they would report on the percent of patients who were eligible for that service who did receive a reminder over a denominator of all patients who are potentially eligible based on meeting certain demographic criteria and who had not already received the service. The denominator is all people who are eligible and hadn't yet received the service. The numerator is all eligible patients who did receive the reminder according to their preference.

Comments? I know that people had – originally there were five different potential options, so let me hear other suggestions.

Neil Calman - Institute for Family Health - President & Cofounder
This is basically for a condition of the provider's preference.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. This is to respond to the NPRM, which had difficulty coming up with a measure, so for all preventative services, etc. That question. And so they chose instead to say, well, let's see. Folks over 50 probably need reminders, and so let's make sure that half of them receive some kind of reminder. This is an alternative to that approach, and it also addressed the concern that folks had of, well, what do you do about the under 50.

Neil Calman - Institute for Family Health - President & Cofounder
I like this a lot.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, I think this is good. This is George. You say who received a reminder or was sent a reminder?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I wrote it as who had received. Now that's what we would like to do, but you're right. That does make it more onerous on us. Ultimately, we want to do it that way, but I think you're right that it should be sent.

Neil Calman - Institute for Family Health - President & Cofounder
I think, if we're going to change the words, that we should say who were reminded, because we agreed that it wasn't just necessarily sent by mail. It could be phoned. It could be outreached with an outreach worker. It could be, there are a lot of ways of doing this reminder stuff.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Neil Calman - Institute for Family Health - President & Cofounder
So I think we should just say who were reminded.

M
My point is just I don't want them to have to call the people and ask if they got it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct.

Neil Calman - Institute for Family Health - President & Cofounder
Exactly.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll signal in 2015, it'd be a dream to say we were all connected, and your PHRs were connected, so we know. It'll automatically survey people. I'm thinking about a new way of doing public health reporting that the CDC was able to send out these questionnaires, and so we would have a better understanding of who received what kinds of services. But anyway, for stage one, yes, were reminded sounds like good wording. Other comments? Is that an adoption of this wording?

M
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes, I think it's fine.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll change it to "were reminded" to give that flexibility. The second piece, and this is probably going to be a bigger discussion, was Charlene had suggested the notion of getting partial credit, and others that have reacted to the NPRM have suggested giving partial credit. A strategy was mandatory versus optional. Charlene worked with Neil and Christine to come up with some principles about how you would do this. But there aren't any suggestions on what examples that would fit those principles to determine between, distinguish between mandatory and optional. But maybe just open it up to questions, or do you want to go over the principles, Charlene?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. I can do that. Again, I think I don't represent just myself in this. There's been a lot of recognition that with the combination of the high bar being set, plus the number of elements that it could be a deterrent. So if there was some way to add some flexibility in the selection process, that would be a positive step.

To that end, I actually did a little bit of work to actually drill down on the hospital side to see if I could sort out some mandatory and, if you will, elective ones. The concept was we could probably narrow it. Again, using certain criteria to go through that process, and we could narrow it down to some that we felt would be mandatory and some that we felt would be better off if, if you will, elective. Leaving them on the list as a signal that this is where we're going, but it would give them flexibility to do some of those, but not necessarily all of those. But that process, you know, it was like something that I'd done with some of our customers, so it's not something that was vetted, if you will, at a workgroup level.

But at the end of the day, it did work out so that there were certain ones that could be considered mandatory and some that could be considered elective. Then the concept of the approach, and again, there's a lot of different approaches that can be used. I think CMS actually has some of these approaches in some of their rules already is they would choose from some subset of those to equal a bar.

In the legislation you can't, for instance, say I'm going to give you partial credit and pay you partially. But you can say, let's lower, you know, and do 80%, as opposed. And I don't know if we want to use 80% because 80% is kind of the bar they had to set for each measure, but some number less than 100% to provide some flexibility in getting there. The document that we put together kind of says, and it's kind of an approach. You have that document?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I believe … does.

M
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The document actually breaks out the process in two steps, and this is kind of where it gets a little bit cloudy. One is to actually, if you will, go through the objectives and the measures, and make sure that what's being asked for makes sense. Again, use some of the guidelines we've talked about before. For instance, it shouldn't be so onerous to capture the measure that it can't be done, or that the bar is too high, and maybe we should just attest.

Again, there's been other industry efforts to kind of look at how we could make even the process of attesting and the process of reporting as least onerous as possible as we can in the industry, so there's

some cleanup that could be done. I think we've been doing that as part of this process. For instance, just the one that we did, that cleans up the content of those matrices, so there's a little bit of work there.

Then the second part of the process, we actually did, we defined some principles that we would evaluate the bar against. And I guess that's what we really wanted to discuss today was to actually go through those principles. The first principle, and Christine, help me with this. We pulled from the rule and said, again, you know, the purpose of the rule is to really support meaningful use, and actually, in our workgroup, we tended to combine some of those, but meaningful use in such as way that the goals of healthcare improvement would be achieved, and in such a way that you would be able to exchange information. You'd be able to report quality, and have a secure infrastructure.

Those three lines were kind of pulled directly, or Christine actually pulled directly from the legislation. Again, that just framed. I think it's all our principles, and I think I start to get overlapping with other principles. Any comment on that one?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You might want to go through all of your principles … because we can't spend the whole time on this, I don't think.

Neil Calman - Institute for Family Health - President & Cofounder
This is Neil. Could I just clarify something? The purpose, we're not going to actually go through and try to edit these, right? Are you suggesting that these get put somehow, that we suggest that the text of this gets somehow put into the document, or are you suggesting that we just sort of have this as guidelines for ourselves when we're looking to potentially lower the bar somewhat on the measures, right?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. I'm okay with that.

Neil Calman - Institute for Family Health - President & Cofounder
Then I think we could just go through these quickly, and not necessarily have to discuss the principles.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Then the second one was really to go through balance achievability because, again, the concept was we want a broad array. We want adoption. We want to encourage that across a large set of providers with what's available in products that are available today, certified or potentially certified. And, to many of us, we were all marching along. The CCHIT 2009 roadmap, that kind of was our guide until the policy made some shifts. But again, there's got to be a balance of the reality, as well as the workforce necessary to do it, as well as the change process necessary in the institutions to accomplish that. We got a balance and had that discussion.

We want to make sure that if there's a potential of doing things moving forward, we don't want them to have to put it in one … rework it the right way. We all know the intent. I think the objectives are written with the right intent. And we don't want to have loopholes accomplished in the meantime to kind of check the box, so that was kind of the point … might end up with loopholes.

…again, where we can, we're going to designate things. The goal would be across each of the functional priority areas, we want to choose one. And where we choose one, we want to harmonize across ECs and hospitals, if that makes sense. We want to make sure, at the end of the day, regardless, and I think it overlaps with the previous one, we can't miss two things: sharing of information that's critical, and

reporting of quality measures. Then the last thing was if there's elements that--and this is also, I think, referred to above--that really advance our infrastructure, don't miss those either.

Those were the concepts and then the document also includes kind of this implementation approach that I was talking about is that you'd set some bar. Again, there are a lot of different approaches. I don't know if we want to make that recommendation. But you could say, okay. There's these many mandatory, and this many that are electives. You have to do the mandatory, plus some number of the elective, coming up to some bar, or just some number of the electives with the implication that those things that are elective will become mandatory in the next stage.

But it gives the flexibility that those people who are further advanced can do those elective ones and get them done with. And there will be those people that do it. For those people who aren't advanced can do the minimum, but they'll know what's coming, and they'll be able to do the things that kind of match where they're at today. Then, as we strengthen the bar going forward and become more stringent, we can get it aligned kind of moving the market from where it's at today with some flexibility and without having to rip and replace, frankly, to a more stringent bar moving forward. That was the concept.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks, Charlene. That is a more detailed sort of proposal that Charlene raised at our last group. I think the group liked the attractiveness … demonstrate some flexibility, and so, one, having some floor, and then, two, having a signal. Now let me just remind ourselves that I think, in a sense, we pursued that strategy in the way we did stages, you know, phase one, two, and three, now called stage one, two, and three, so that stage one, 2011, would be some floor for 2011, and then the way we signal it was to put placeholders in for 2013 and 2015, now stage two and three.

In a sense, we already that concept built into our framework, and I think the net effect is that you're trying to lower that bar and build more flexibility even in a given stage like stage one.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, if we could. Except, Paul, I think what we're responding to is the NPRM, and the NPRM raised the bar that I think the policy committee set.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I see what you're saying.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's what I think we have to respond to. So if nothing changes, you know, all our recommendations are ignored, I think we need to be responding to the bar, as it's set. So it's at 80% on a lot of the things that I don't think some of those were necessarily the intent of this committee. That's all.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll make one comment that we also had a little bit an exchange with you, at least with some of the people on this call that just like we set out some principles for core measures, what we thought were core measures at the time. When you go back and try to do the homework and devil in the details thing, then we found out we couldn't come up with measures, at least the last call, last meeting, that met those criteria. Similarly, when we started the exercise of meeting your principles and saying, which could be optional and meet your principles, that turned out to be challenging. So that's….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think it will be challenging.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We have a limited time, and I don't think what we want to do is to revisit our entire process by which we established the original matrix because that's also probably not appropriate. And so the question is, did we already do what you're suggesting and came up with these as a floor with the future stages as being the signal. And how do we address your question, which is, well actually you're saying that the NPRM came up and raised the bar, which didn't meet our original intent. Comments on this?

Deven McGraw - Center for Democracy & Technology – Director
I think it's pretty clear that what's being suggested here, and I think Charlene is right. We're not just hearing it from you. We're hearing it from a lot of sectors is that, notwithstanding an attempt to reach a set of stage one criteria that set the bar ambitious enough to justifier expense, but not so ambitious that people wouldn't come in. That even what we've got on the table for that stage may be more than can be done, is I think what she's suggesting.

I read the principles. I didn't necessarily disagree with them. But I think if we don't have the time to present something at a level of detail about how CMS would go about maybe making some of them easier, I'm kind of hard pressed to put that forward as a principle for fear that the way it could get operationalized would be not a sort of careful consideration of incremental things where we might be able to give folks some optionality, and instead would be a sort of machete approach. We'll cut off this category, or we'll cut off this piece.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, and my concern would be there'll be others that do this, you know, so either we find a way or we're silent on it. I hear you.

Neil Calman - Institute for Family Health - President & Cofounder
I think there's one. If you think about what our long-range goal is, and I mean long-range meaning like three to four years, like say phase one and phase two. I think we can state pretty clearly where we want people to be by 2013. And I think, I would not have a problem not specifying mandatory versus optional, but just saying that here's the list, and you need to, at whatever level we suggest, you need to be able to do 80% of the things on this list or 50% of the things on this list, whatever we choose because, clearly by 2013, people are being signaled that they're going to need to do all the things on the list. I think what I'm hearing, and I've heard this also from a lot of different folks, that people are taking multiple pathways. There's not like a very specific way that first you role this out, and then you roll out that function, and then you do this.

People are coming at it from lots of different directions and already have ongoing projects that we want to sort of support. I wouldn't have any problem if we just were silent on which are the absolutes and which are the optional, and just said here's the list of things, and we expect that some percentage of these you will be able to attest that some percentage of these are in place. And we could then discuss what that percentage would be.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I need to speak up for Christine who is not here. Clearly let's even say it's 80%, let alone 50%. You could say, well, let's drop the patient access.

Deven McGraw - Center for Democracy & Technology – Director
Or privacy and security.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Or privacy and security.

Neil Calman - Institute for Family Health - President & Cofounder
No, you can't drop that. Come on.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
…security, Deven.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Now that's our problem. We have the slippery slope problem.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We either have to be as granular as was originally intimated, you know, here is the mandatory, the floor, and here's the optional, which again is dividing what we started with, or we – or I don't know.

Neil Calman - Institute for Family Health - President & Cofounder
Middle ground, which is, there's a middle ground, which is, they could be divided up into the five MU objectives, and to state that there's got to be at least one of the measures in each objective, and 80% of the measures overall. And that would mean that you couldn't just decide patient engagement wasn't important.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think George was looking to speak.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. The one I suggested was you can drop up to three from quality, one from the next three groups, and you can't drop security. That's 80%, because there's about 15+ quality measures in the first group, and there are about 3 to 5 in the second, third, and fourth groups, and one in the last group. So I just did three, one, one, one, and zero is how many you could drop.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
ARE you talking the quality measures, are you talking--?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I said that you couldn't drop the quality measures. If we drop the core, then we're down to three quality measures anyway for doctors. I didn't think that was too bad. But one of the functional metrics is report quality measures to CMS. And I didn't think CMS would let us drop that one.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, I didn't either.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair

Leaving that, but other than that one, there are 15 other functional measures in the quality, safety, the first national priorities partnership group. And so I said you could drop three of them, and I just said any three of them.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
That would be a way to do about 80% without dropping any one category. But I still have to look further to make sure I'm not setting up some disaster. Although CMS is going to look and see … too.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
We're not the last ones looking at this.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
We're just stating there needs to be….

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
You could say that's a possible way to do it, and let them do whatever they want.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
But I think where this group could say is exactly what you said is provide the framework or the guidelines, not necessarily the decision making, because they're going to get all this input from the industry about the elements on their own.

Neil Calman - Institute for Family Health - President & Cofounder
But I like what you said, George, because I think it's sensible, and we've been asked to make our comments as specific as possible.

Tony Trenkle – CMS – Director of OESS
Right. This is Tony. I would suggest the framework and rationale behind that would be very helpful to us. But as you said, we're going to get a lot of comments from a variety of sources, so we just have to kind of pull together, along with what you provide to us.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we want to go as far as the 3/1/1/1 – I feel like I'm going through an airport. Anyway, I think we want go that far because otherwise it's not as helpful.

Tony Trenkle – CMS – Director of OESS
Right. I agree.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
This is Dave Bates. I feel strongly that you need to relax them some, and I'm hearing, as I suspect everybody else is, that very few entities will be able to meet them the way that … now, and it's not exactly clear to me what exactly the best way is to relax them, bu I'm in favor as being as specific as possible. This is the first time I've really processed the 3/1/1, so I … whether that's enough relaxation.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
One, it sounds like, and I'm going to check this. It sounds like we have concensus about a desire to relax some of the standards. Two, maybe what we do is if that's true, maybe what we do is we process over e-mail more about the 3/1/1/1, and with some concrete checking. All of us can do that due diligence before we put that in front of the committee next week as our draft proposal. One is how are we doing on concensus in terms of, as written in the NPRM, we feel that some flexibility is warranted.

M
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes, I think so.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Anybody apposed to that?

Art Davidson - Public Health Informatics at Denver Public Health – Director
This is Art. I agree with that as long as it's qualified. We're just talking about stage one here.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We'll limit it to stage one too. Okay. Then do we all want to do our due diligence around the 3/1/1/1?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Explain what that means again, Paul.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Go ahead, George.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
It means that in the first group, quality and safety and efficiency, you can drop up to three measures, but not the report measures to CMS. Second, in the patient engagement, I don't have it in front of me right this second. The next three groups, you can drop one measure each. And then the last group is security. It has only one measure, so you can't drop that.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes….

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I think people will be able to do that anyway, so I'm not worried about that one.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
We do, actually, in the cleanup, we made a recommendation … merge them and make them the same, but that'll all come in, in the detail, so I don't think it's hurt by this.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Paul, could I ask? In Charlene's document, it talks about measures that force more manual labor. I'm not allowed to say this because I didn't e-mail it beforehand, but a thought occurred to me looking at it right

this second is that you could consider a thing where you do a count divided by the total number of patients. That is, two things that are easy to measure.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
And we don't worry about whether it's 80% or 20%. The point is that they do it for some, and to account for the volume of that person's practice. We just do the total number of patients in the practice that are billed that year, the total number of patients billed that year, and then have one order per patient or something.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I'm just saying that that's another way to avoid this problem where we're hearing a lot of complaints about people not wanting to count how many orders they don't do.

Deven McGraw - Center for Democracy & Technology – Director
Right, right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Actually, this is Charlene, that came up on a call yesterday, so if there was some standard like that that we could agree to, I don't think you'd get resistance to doing it. It's just the undo burden you get the resistance on.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
So I would suggest we not talk about it now, but it's part of the document we did receive, so that's good, so it qualifies it a little bit. And that I can put in that sentence in that document and see what happens.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Great. That was Neil or George?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
That was George. Sorry.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks.

Deven McGraw - Center for Democracy & Technology – Director
This is Deven. I will say, I'm very much warming to this concept, George. And, of course, I especially like that you don't get a break on the security stuff. But I do want to say that the privacy and security workgroup is putting a few things on the table to beef that security piece up a bit, but it's nothing that would require extensive outside calculation. It's more along the lines of clarifying what is meant by security assessment, making sure that providers have adequate education about it, and noting that an attestation ought to be that you did the assessment, and that you implemented and addressed any deficiencies. And that we are putting back on the table the notion of compliance with HIPAA, but it's a pretty high bar threshold for not meeting meaningful use, which is that you actually have to be at the point

of being fined for a willful neglect or a criminal violation in order to be not meaningfully using because of a privacy and security concern.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Okay. That's good that your group is going ahead with that. I think that our recommendation, if it was 3/1/1/1/0, is kind of our intent, and then CMS would interpret it.

Deven McGraw - Center for Democracy & Technology – Director
Of course.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
If they change, it'll be up to CMS to decide that. The big question I have is whether 3/1/1/1 or anything else really makes their lives easy substantially or is it just a show. And that's really what I want to think about in the next day or two.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think my take is from the analysis it'll help.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Very good. Are we ready to move on? Thank you, Charlene, Neil, and Christine for preparing that discussion. The next thing is some of the clarification questions, and I think I'm going to pick on a few of these because some of these are not relevant anymore. But speaking of relevant, I think one of the things that we did leave undefined in our original matrix and appears that same way in the NPRM is the whole notion of clinical summaries at transitions.

And we included the phrase relevant encounter, and it's not clear to me that we gave a good definition of that. Comments about that? I'm trying to remember. It was in the transitions of care part of … category one or the care coordination. And we said that clinical summaries should be available electronically for each transition of care or relevant encounter.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, what is it you want us to do?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Define relevant encounter.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
We spent hours defining that here, hours and days. It's not trivial.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. That's why I think we need to take personal responsibility for this because we used that term. You know, here was the original thought. I recall some of the discussion. On the one hand, we started. We mentioned a point of having this available for every encounter. In a sense, it's like the discharge instructions for an admission. Well, it's what you leave. It's the after visit summary for an encounter, and that seemed a bit much, and that's how we came to the phrase relevant encounter, but we did not define it at that time.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Well, I think part of the issue was that you could have an encounter one day and the next day, and it doesn't seem relevant at that point to have another medication reconciliation happen.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. But we need to be more specific somehow. I'll read the original words, the words that are in the NPRM. "Perform medication reconciliation at relevant encounters and each transition of care."

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. What we had thought, at least where it's at today, I'll do a hospital, and again, they're have to define ambulatory. That meant we had to do it at admission. For at least stage one, we have to do it at admission and at discharge, and we would assume that, for the care summary, we might get one at admission and, at discharge, we'd have to be able to produce one. Moving outside the box of the provider space is kind of what we thought was transitions in stage one.

For a physician office, when they would generate a referral, then that would be, they're moving the patient to another venue of care. That would be the transition. That would be a huge step forward for the industry.

Neil Calman - Institute for Family Health - President & Cofounder
This is Neil. I think we have to bifurcate the inpatient. This is clearly a different story for the inpatient versus outpatient setting.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
So we need to come up with language for both, I think.

Art Davidson - Public Health Informatics at Denver Public Health – Director
But didn't Charlene just give us some language for the hospitals?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, I can do that.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Didn't she say at admission and discharge?

Neil Calman - Institute for Family Health - President & Cofounder
Right, but I'm trying to say that that's – we also have to deal with language that's specific to the eligible providers.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Right. We need to work on the left box.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Even transition of care was, I think, changed. I think we meant transition of care, transition from sites of care.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Yes, sites.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And I think it got defined a bit broader in the NPRM.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. That would work for a hospital, sites of care too.

Neil Calman - Institute for Family Health - President & Cofounder
Can I throw out some language that I just scribbled as a proposal?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Sure.

Neil Calman - Institute for Family Health - President & Cofounder
For the eligible provider. At admission to the practice, when a patient returns to the eligible provider from an inpatient stay, or when returning from a specialty consultation where medications have been changed.

M
Good.

Neil Calman - Institute for Family Health - President & Cofounder
I mean, those are three critical times. I think there are other times as well. We're not people they can't do it at other times. But if we're trying to be specific as to the most critical, those would be the three that I would put down.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Say that again.

Neil Calman - Institute for Family Health - President & Cofounder
At admission to the practice, when the patient returns to the eligible provider from an inpatient stay, or when returning from a specialty consultation where medications have been changed.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
In some sense, if you generalize the word site of care, transition from a site of care to a provider of care, would that cover it?

Neil Calman - Institute for Family Health - President & Cofounder
I don't know how people are going to still – if you're in a group practice, does it mean if you're covering for your partner? I mean, I think that leaves a lot of ambiguity.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And you've got to be careful where it's an integrated continuum, like the clinic settings when you don't necessarily, if you're an integrated system, need to do that either, right? It's already in the system.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me restate your interfaces then. It's admission, discharge, arrival at EP, and crossing specialty primary care.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

And I think that last one is tricky because what if you're an integrated practice? Do you need it then?

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Yes. Just because it's in the EHR doesn't mean that that primary care provider is cognizant of it.

Neil Calman - Institute for Family Health - President & Cofounder
Right, or that the patient really understands. Those are the times when things get really confused.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
It is important in the settings of care to include long-term care and other situations like that.

Neil Calman - Institute for Family Health - President & Cofounder
Right. You could count that as an inpatient stay.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The issue that you have there is that's not covered. We'll get in trouble because that's not covered under the law.

Neil Calman - Institute for Family Health - President & Cofounder
What's not?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Those other sites of care.

Neil Calman - Institute for Family Health - President & Cofounder
That doesn't matter.

Art Davidson - Public Health Informatics at Denver Public Health – Director
You need to do medication reconciliation when they come back from the site.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I'm not disagreeing. I'm just saying it's complicated.

Neil Calman - Institute for Family Health - President & Cofounder
Well, they're not….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
As long as we keep the boundaries crisp in terms of – that's tough. From long-term care, they're not automated. You're not going to get one.

Neil Calman - Institute for Family Health - President & Cofounder
Get one what?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
A care record summary from that space, and you can't expect one.

Art Davidson - Public Health Informatics at Denver Public Health – Director

But we expect them to do a medication reconciliation.

Neil Calman - Institute for Family Health - President & Cofounder
Exactly.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
You typically actually get a piece of paper.

Neil Calman - Institute for Family Health - President & Cofounder
Yes. That's why it's even more important. That's exactly when the medication reconciliation's have to be done.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
How do you attest to it though? How do you measure it?

Neil Calman - Institute for Family Health - President & Cofounder
You attest to the fact that you're doing these.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. That's why I corrected myself. How do you measure it?

Neil Calman - Institute for Family Health - President & Cofounder
You don't want to do this by attestation?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, it is attestation, but there has to be some way to audit it, and ideally audit it electronically. For example, if you cause paper to be printed, as they go from one setting to another, that can be reported upon. The act of printing is, I mean, you just assume that that was printed and distributed.

Neil Calman - Institute for Family Health - President & Cofounder
But medication reconciliation isn't printing something. Medication reconciliation is a provider sitting with the patient and going over a current list of medications, and a note is written in the chart that said medication reconciliation has been performed. That note basically, you know, we have such a note that gets put in the chart when you perform a medication reconciliation. It says all the patient's current medications have been reviewed with the patient, etc. There's a process. And that process, like everything else you do in practice, should be documented in the record. That's how I would audit it.

Art Davidson - Public Health Informatics at Denver Public Health – Director
I think Paul's question though, Neil, is how would you know that they came from another setting or a referral?

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
And how would you know that you did that medication reconciliation and documented it on that return?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What I'm hoping is that these will become coded things in the EHR so that you can check this process that I did a med reconciliation.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
Let me just say that I don't think that the ability to measure it electronically should be – the inability to do that should be a deterrent from putting an important requirement in place.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm saying the opposite. I'm looking at it from the opposite perspective. I would like the EHRs to be certified to be able to record this, so that the burden to attest, audit, and check is less.

Neil Calman - Institute for Family Health - President & Cofounder
I see.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It is not in congruent with what you said.

Neil Calman - Institute for Family Health - President & Cofounder
You'd have to have – what you'd have to be able to do is have the EHR, when a consultation report is returned, somehow know that that consultation report included some change of medications. I just think that we're – it's going to be – that would be very tough.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What I'm saying is that it doesn't include the condition of change in medication because….

Neil Calman - Institute for Family Health - President & Cofounder
I see. Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
…neither the human, nor the computer – well, the computer actually can stand a better chance. I'd like to also perhaps broaden the discussion not just to relevant encounter. The whole concept of transition occurs, so that boundary, there's a number of objectives that are being proposed at that boundary. One is med reconciliation, which we talked about. Another is provide summary care records.

I think it would be helpful if we could come up with a definition of transition of care for the purposes of this program that would encompass transition, the normal way we think of transitions, and also the relevant encounter concept. If we could come back, so go back to somebody mentioned the use of the term setting of care. Let's talk about, if we could say, when you go from one setting to another, those are times when it's important that you have a clinical summary and med reconciliation occur.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Then what we would define is for the purpose of the NPRM or this HIT program, what setting of care means. And so one example is if I tried to encompass our previous discussion, a setting of care is clearly

a hospital. It is a primary care provider practice, and it is a specialty care provider practice, and we could also include things like long-term care and home health. If those are settings of care, then for each transition, there should be available clinical summaries and actually should occur med reconciliation.

Neil Calman - Institute for Family Health - President & Cofounder
Now I know why they made you the chair. I think that's perfect.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
How do other people think?

Art Davidson - Public Health Informatics at Denver Public Health – Director
I agree.

Deven McGraw - Center for Democracy & Technology – Director
I agree.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I guess I'll have to put those into words, and what would happen is those would fill in the blanks for all the different objectives that deal with this interface issue.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Hopefully that would be clearer to everybody.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, I'm going to look. There might be an industry definition that aligns exactly with what you said. I'll see if I can find it for you and send it to you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Tony, are we being helpful?

Tony Trenkle – CMS – Director of OESS
Yes, Paul. I believe so.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm helping.

Tony Trenkle – CMS – Director of OESS
You're helping.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
All right. Good. Another topic we had, and we probably covered it. Let me see if there are any remaining issues about the whole access versus copy. This has to do with the patient, engage the patient and families. We had two requirements actually. One is getting the right to receive a copy of their electronic summary, and the other was access to.

It turns out that one of the things that was put in was the timeliness was specified. The copy was, I think, 48 hours, and the access to was 96 hours. I know we've had other comments, and I certainly have them

as well. Forty-eight hours could be pretty tough in an ambulatory care setting, considering weekends and holidays, for example.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes, and isn't it also supposed to be the complete record?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I don't think it's – I'll have to try to find out here.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Actually, that's some of the confusion that often like what's suggested is not clear … suggested or there are examples.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm reading. This is provide patients with electronic copy of their health information upon request. The measure, at least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours. You're right, David. In fact, in the objective, it had copy of their health information, open print, including diagnostic test results, problem lists, medication lists, and allergies, so that does … everything. So that might be something we want to comment on. I think we actually intended the including to be actually just the … then you'd say what test results.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I mean, some people have implemented it. They just do a minimum, like get at least the problem list and that. Really, you'd like it to come as soon as possible, but there is policy already in medical records where they have to respond to requests for your medical records, and there are already timeframes around that. I know that AHIMA is actually providing some comment. The hope would be to align with what that requirement is today to provide access, at least in the hospital setting, and make sure that you can provide it in an electronic way, in addition to paper.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Actually, I think those kinds of requirements are something on the order of like 30 days, you know, those kinds of language.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. It probably is, so do we have to change the AHIMA requirement? Do those have to change? I don't know. I don't have all that detail yet.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Our intent was to make sure they could get, unlike HIPAA, which said … permissive rule. We were hoping that we would require, for people with an EHR, that they also make available electronic copies to patients. That was the intent behind our suggestion.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
There's a difference between the summary of the record and the whole record too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The way we read it, it was the whole record actually. We read it the other way, so it's a little unclear.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's put some suggestions on the table. David, it's your suggestion then that we require clinical – that provide patient with an electronic clinical summary.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes, and that, I think, could be within a relatively short timeframe. But the full record, I think it should be a longer timeframe.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
But this also relates then. We just discussed summaries of care. Again, I think we need to get our words cleaned up here because, in the industry, we kind of moved away from summary of care to call it, there's another term out there, and I'm not even going to know it now, the medical summary. We're starting to call things different things when they end up constituting the same thing from a systems perspective, so it gets really confusing.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I'm all for using whatever….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. The current languages. I have to get the current language, but summary of care, we kind of move to these medical record summaries or something, a different concept, but all that word. But it's the same thing you're talking about now, as what we just talked about a few minutes ago. They should be able to – we would want to produce them in the same way.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think it's clinical summaries is the word, but do we want to define that? We previously said problems, meds, allergies, and we also included diagnostic test results. I can see that that can be open to interpretation, whether it has to be comprehensive or not.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Should we swap out the discharge summary, which typically means this fully dictated note to something that's something that's shorter?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We talked about discharge. I'm not in the right place to look at that. Maybe we can stick on this, so I don't have to swap back and forth. This is the electronic copy of their health information objective.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Right, and that's including diagnostic test results, problem lists, medication lists, allergies, discharge summary….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here I see it. Yes. That's correct. Under hospital, that's correct.

Art Davidson - Public Health Informatics at Denver Public Health – Director
I think that, as Dave Bates said earlier, most of these things are probably okay. It's just this, I think this word discharge summary, is the one that's confusing, and that's what Charlene is pointing to.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think discharge summary is pretty well defined in the HEMA terms. Am I mistaken on that?

Art Davidson - Public Health Informatics at Denver Public Health – Director
Is that what needs to be done in 30 days, the dictated note?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. I mean, if you've got to wait for the discharge summary, the case is, most of them are transcribed today, so it's a tradeoff. That's all. In the standard today, the patient summary includes administrative, demographic, and clinical data about the patient, and it includes the meds, the lists, the allergies, the problem list, optional procedures, so that's the model that we're all following, but it does not encompass today the discharge summary, although there's a version of the document that is the discharge summary.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's go back to our intent. The concept, I think, we meant is the clinical summary because I think once we get into all records, it's not as if we can't produce. I'm not even sure that systems can produce "the entire medical record" electronically. I think our intent was a clinical summary, so that they could note for themselves. They could communicate to the next care provider, etc. Is that true?

Art Davidson - Public Health Informatics at Denver Public Health – Director
I agree with you, Paul.

Deven McGraw - Center for Democracy & Technology – Director
Yes, I think that's right.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I do too.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Then now we have to define what a clinical summary is, and as I say, we could start with the problem meds and allergies, and then how would we word the diagnostic test results so that it's not absolutely everything?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Recent test results or something on that.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I mean, from a systems perspective, and I'm not sure how this correlates to what's in the standard right now, but again, we usually give, you know, the most recent or something. You want the last vital signs and that kind of stuff. So you always serve up the most current, basically, but you don't want every vital sign that was collected in the hospital. That's where it gets a little tricky. At point of discharge, what your vital signs are, your last test results, so you give them the last ones, but you don't give them the whole range of them while they're there.

Art Davidson - Public Health Informatics at Denver Public Health – Director
First, Paul, I guess we're saying that we'll change the word "health information" to "clinical summary". Is that what you're suggesting?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct, and then we're now working on the definition of that.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Right. One of the things I'm hearing is key diagnostic test results. That might be the … leave that open to interpretation.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Recent might be an easier thing to do.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's talk about one setting at a time. From the EP setting, recent could be defined since the last visit or something. You could figure out definitions for that.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
This objective was meeting two needs. One was the diagnostic test results is to reduce diagnostic, repeat diagnostic testing. So we're hoping that the cath report would go over. Well, you don't get two caths, but two stress tests. You don't get a duplicate stress test because they have it on their CD. On the other hand, we were trying to give people a summary of what happened in the most recent encounter, so we kind of mixed them in our objective, I think.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Georg H.
If we just make it a summary, then we eliminate the diagnostic test duplication solution. But maybe it's not feasible right now, in which case, that's life.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think that's where we are, George. In other words, we aren't at the point of specifying the entire record. We may do that in later stages, but right now I think we're trying to help with the care coordination in some feasible, definable way. The most recent definition of the relevant diagnostic test is recent. How do people feel about that?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Recent or relevant, but relevant is hard to define.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, it's harder to define.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
…you have a diagnosis, but then you know which ones you're supposed to be handing off, and then….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
David Bates' definition was recent.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine

It just seems to me that that meets with what Charlene is saying. That's kind of what the industry does now.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
That's reasonable.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm thinking it's reasonable. Yes. Let's try that out. Now let's switch over to hospital. Let me throw out something, and instead of saying these things, just say discharge summary. The reason for suggesting that is I think that does have a definition of what has to be included, and then hence we don't have to redefine it.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Then your only issue is your timeframe then, Paul, in stage one to get it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. That's one problem at a time.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Let me kind of – there is a definition. It's a standard. That's good. But if it was that thing that you could gather, and you'd make a tradeoff if you want it right away, like when the patient walks out the door. Then you don't have to wait for the transcribed report. Otherwise, you're going to be delayed, so that's the tradeoff.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we have a separate objective that talks about discharge instructions, and that is what you get upon discharge, so that's also a requirement, so we can rely on that.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, but the discharge summary is what the physician writes and are accountable to send to the primary care doc in terms of this is what happened, not the instructions. It's a separate process.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. This is the discharge summary, I believe.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Yes, I think the timing for a discharge summary is difficult at 48 hours.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
We have two choices. Either we leave it as recent diagnostic test results, problem list, medication list, allergies, and procedures within 48 hours, or we say discharge summary within whatever the right time is.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm going to try to find our discharge instructions because I believe we have a separate one.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
No, discharge summary, I mean. For instructions, I agree with. That's fine.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, but see, we do have a discharge instructions, and that is at time of discharge, so I think we have that covered.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Right, so I'm saying that for the on that's 48 hours, we need to list everything except for the discharge summary and leave it at 48 hours, or we replace all of it with just the discharge summary and make it whatever it is, one week, two weeks, three weeks, whatever the law is.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Then you've got to go with the policies that are set by medical records.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. Exactly.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I would suggest that our contribution here is to make it available electronically, and then we just follow the definition of discharge summary and the timing based on whatever is current standards.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Neil Calman - Institute for Family Health - President & Cofounder
Except, I don't think we're accomplishing anything in terms of improving communication--

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I don't either.

Neil Calman - Institute for Family Health - President & Cofounder
--if we make it current standards. I mean, it's absurd when people come out of the hospital, and you're seeing them a week later, and there's nothing available in terms of a discharge summary.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
You've got to get all those doctors to sign those summaries. It's a pain.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
The other choice is just to do diagnostic test results, problem lists, medication lists, allergies, and procedures within 48 hours, and we just do a parallel summary to the discharge summary. That's the other choice.

Neil Calman - Institute for Family Health - President & Cofounder
If you're doing it electronically, there's no reason that stuff shouldn't be available at the time of discharge.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, but you don't have physician documentation in the hospital until stage two.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Right, but it doesn't ask for … that's not in the list. We'd have to have a problem list, medication list, allergies, recent diagnostic test results, and coded procedures.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Isn't that on the discharge instructions?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
No.

Neil Calman - Institute for Family Health - President & Cofounder
No.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
No. Think of the discharge instructions you get today. It's a printout that says, when you go home, make sure that you, you know, don't drive for 14, you know, for 24 hours. You know, it's like, that's your discharge instructions.

Neil Calman - Institute for Family Health - President & Cofounder
And it's a fifth copy of an NCR handwritten form that nobody can read, and that's a huge quality issue.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Exactly.

Neil Calman - Institute for Family Health - President & Cofounder
I mean, this is an area where I think we need to call out some very specific progress that needs to be made, and not sort of accept the existing standards.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Are you saying to make it…?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It seemed to me, rather than trying to transform the transcription process yet, you want to drive value from the data you're capturing … transforming every process in the settings yet. But use the data that you're capturing, and make it a value. Applying it to the standards that are defined, you know, I think we could do that, and I think that would be good.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's revisit George's suggestion. Essentially, it's the same wording as the EP.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Yes.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And we're just eliminating discharge summary, the standard defined discharge summary.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Right.

Art Davidson - Public Health Informatics at Denver Public Health – Director
That's what I agree with.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Then, George, what would you do with diagnostic tests again?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I guess, do the same thing.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But recent now means all.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Let me think about that. You might have to say relevant.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
George, think about coded procedures too. We're struggling with coded procedures so think about that, to capture them … fast.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We might have to use some term like summary diagnostic test results, something like that….

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I mean, we could definitely capture the diagnostic test results. They're there. Anything that depends on medical records is where we get a little….

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Yes. I don't know about procedures. I'd have to see.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Think about that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Think about that. Now we're at the 48 hours. What do people think about, in the redefined world, we're talking about recent things, so active problems, meds, allergies, and recent test results and procedures? When is it reasonable to make that available electronically?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
I would say 48 hours or shorter, and that's how we should define our things that we're including. In other words, we should draw the line at 48 hours, and see what we include rather than the other way around.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
One of the problems though is for the non-hospital, for the EPs, 48 hours, we have the business hours problem.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right. Do you just make it 72? That's a killer too.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
All right. Yes, I see. Paul, I have to go off now, I'm afraid.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You're going to get back to your homework?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
What's that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You're going to get us back your homework on these test results and procedures?

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
Test results and procedures? You mean on this?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
…yes, working on the words.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Because it's the coded procedures … challenged.

George Hripcsak - Dept. of Biomedical Informatics Columbia University – Chair
….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
At least in the near term, that'll come.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

So 48 hours, do we go to 72 or 96? What's reasonable? Or do we even have two standards? But we want to encourage follow-up after a hospitalization, so we may not want to relax the 48 for hospital, but EPs are more….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Hospitals that are doing this well right, and again, they have a little process where the physician actually does a summary discharge, which is really nice, the patient walks out with it. But I don't want to make that as a standard, so strike the record. But it looks like that's where we're going to want to go.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's think about hospitals and EPs separately. We can put them together if that's where we end up. The hospital at 48 hours may not be a bad thing because we do want them to get followed up.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, and I think that would help the readmission stuff because I think if they're not back within that, like that 72 hour window is scary because then if they don't show back up in 72 hours, then they're out of the window. Didn't someone just die because they didn't show up within 72 hours, one of our congressmen?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What about the EPs? What's a reasonable timeframe for them? Is 96 hours an okay … something else? Sorry.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Align it with that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Alight it with that, yes. Some other voices want to speak up?

Art Davidson - Public Health Informatics at Denver Public Health – Director
I guess it's reasonable. At some point, we want this to get faster than that, but to start this, I guess the main thing is to get started.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Good.

Art Davidson - Public Health Informatics at Denver Public Health – Director
…go back to the discharge summary that we took out of the hospital, do we think, in the future or now, we want to add in that that summary should be available, even if it takes two weeks to three or a month to get done? Do we want that to be something included for the patient, a complete discharge summary?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, I think so.

Art Davidson - Public Health Informatics at Denver Public Health – Director

Is that something we want to add at this point, or we'll come back to that in stage two?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
At this point I don't know.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I favor it coming back.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. We're struggling on the – well, we just struggled with the whole flexibility issue, so why would we add something that we'd only have to take out … flexibility? The latest proposal is that we come back it to in stage two.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. One more timeliness issue, a 96-hour timeframe got put in for provide patients with timely electronic access. This is the access versus the copy. I'm not sure where the 96 hours came. It seemed like the most efficient way to satisfy this requirement is to give people, you know, find a way that they can have their own PHR. Presumably, the timeframe is if you end up doing, because there were some examples we gave of a USB drive or a CD. Presumably the 96 was related to that.

I will say the topic of the complete record is raised again because it says provide patient with timely electronic access to their health information … including lab results, problems, meds, allergies. Should we talk about…?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I think it needs to be more specific than that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Is Eva Powell still on the phone?

Eva Powell – National Partnership for Women & Families – Director IT
Yes. This is Eva, and I'm just trying to think through this because I understand the issues that have been mentioned. But my real fear in whittling away at this for patients is the clear benefit to them of identifying errors in the medical record. And it's very clear that there are lots of errors in the medical record, and that patients are some of the most likely people to find those when they can actually get their hands on their medical records. And I worry that if we exclude them from the discharge summary, that some of that benefit or all of that benefit might be lost. And I'm not, I'm still trying to process whether what's actually been agreed upon as to what would be included in the stage one for patients would actually be the degree of information that they really need. It's certainly better than nothing, but I have to say that I'm not comfortable with this.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Eva, there's been a lot of work by really great people on this concept of CCD or care record summary. There's a lot of great content in there. The intension was, there's got to be some confidence, I think, in

the standards that have been thought through because these are really thoughtful people that are putting this content together, and they're very cognizant. They think about what's the necessary data to transfer the patient from one area to another.

As long as I think we vet a little bit on some of the thought process going into some of these standards, you know, they were designed for the continuity of care. That's the path the vendors have been on, and I've been in those meetings where we've debated what is an allergy and on and on. There's a lot of good thought, so we need to leverage some of that.

Eva Powell – National Partnership for Women & Families – Director IT
Yes … specific things that have been mentioned thus far, the complete … what's included in those standards.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, pretty much it's there, and I want to cross check. I mean, I don't memorize it like some of our people do. But I'll cross check it. And again, the concept there is populate it with as much as you can in a coded format as you can, and then also make, of the document, create a human readable form so they could look at it.

Eva Powell – National Partnership for Women & Families – Director IT
Yes.

Deven McGraw - Center for Democracy & Technology – Director
I think this is going back to some conversations that we had when we were first creating the matrix about the distinction between getting a copy of your data, which we know is required under HIPAA, and having some access to data almost in real time. This notion that getting a copy requires the patient to actually ask for it before it's given versus creating sort of these pathways where the technology becomes a tool for more real time interaction between patients and their care providers that involve accessing data.

I think, for example, Paul, the portal that you guys do at the Palo Alto Medical Foundation, and that exist in other places is sort of part of what we sort of envisioned trying to create the pathway to get to. But I acknowledge that there's been some confusion out there about what's the distinction between access and a copy, and what's the right pathway for both the technical innovation in this space, and then getting providers and patients to use it.

I confess that I don't know where the 96 hours comes from, and I like the discharge summary piece is important in creating some time parameters around that is important too. But I feel like there's a piece that was part of our conversations from the very beginning that we may be missing here in our follow through, but I confess that I'm struggling to figure out what we would want to comment on at this stage.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me try to build upon that. If the purpose truly, we essentially wanted them to be able to access their medical record.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It is probably not feasible now to access the entire record just because the products don't do that. That just seems not a stage one thing. And so the 96 probably is a red herring in the sense and, just like you

said, is probably not what we intended by "access". So if we go back to saying what we wanted here is that people have access to key – real time access to key info. Actually, we did use that term – to key information from their health record, period. And that basically means people are going to have a PHR.

Deven McGraw - Center for Democracy & Technology – Director
Right. I mean, again, depending on how you define the PHR, it might be an independent body. For a lot of folks, if they had a portal, some people call it a PHR. Some don't. It's a nomenclature issue that we really don't have to go down that pathway.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The main thing from the provider view, we didn't want to, and again, this is just more of the measurement that we just didn't want to make it, to achieve it, depended on the patient. That was all.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It does say available. People may choose not….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Create an electronic copy on paper.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, we wanted to provide patients with access. We're not forcing them to log in, for example, or even sign up for this. But the purpose was to give them that access. And so I think, consistent with what Deven was saying, we would restate that objective we had, and that would make the 96 hours irrelevant.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Okay, so—

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
How do other people feel about this discussion?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Maybe I don't care. This is eligible professionals. Sorry, sorry.

Deven McGraw - Center for Democracy & Technology – Director
I think Charlene maybe agrees.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Neil, David?

Neil Calman - Institute for Family Health - President & Cofounder
I'm not sure.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
You're not sure.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think the feedback I've heard from the ambulatory practices is not each of them will have their own portal in this timeframe.

Neil Calman - Institute for Family Health - President & Cofounder
The point for me is to be able to use the system to provide the patient the information, but not necessarily that the patients would need to be technologically enabled to do this.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct.

Neil Calman - Institute for Family Health - President & Cofounder
I think that's critical for the people that I take care of.

Deven McGraw - Center for Democracy & Technology – Director
Right. Yes, that's a very good point.

Neil Calman - Institute for Family Health - President & Cofounder
So I think that what you want is the technology should be able to capture and process and put the information out, but the per patient preference piece needs to be highlighted here again that that's not necessarily – electronically is not necessarily the patient may want or may be able to receive it at this time.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We'll make it clear that this is something that is made available, but it's not a requirement that you measure, for example, how many people logged in.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll work on that wording as well. I notice, as I look at this matrix, there's something else that I think got brought in. That is, provide clinical summaries for patients for each office visit.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
And that actually struck us as redundant some of your other ones, so we actually recommended combining that with the one we talked about previously.

Neil Calman - Institute for Family Health - President & Cofounder
I don't know….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's not exactly the same thing.

Neil Calman - Institute for Family Health - President & Cofounder
No.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So do people still want this … so it's a new term, a clinical summary versus access to a large portion of their health record?

Art Davidson - Public Health Informatics at Denver Public Health – Director
That's a term that we had in the matrix.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we had it in stage two.

Art Davidson - Public Health Informatics at Denver Public Health – Director
I believe stage one, I think, Paul, at least the one I'm looking at.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
If it was there, then let's not revisit it.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, how does this differ from the one we just walked through, which is, provide patient with electronic copies of their health information within 96 hours or…?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's different in format, so there's something that creates a clinical summary versus access to your record.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, but this says … create, provide with an electronic copy, and I thought we agreed we were going to call that a clinical summary instead.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's the 48-hour one.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, it sounds to me – it struck me as these were, and we were trying to support these with the same tool, if you will.

Deven McGraw - Center for Democracy & Technology – Director
Well, but I'm not sure that that's appropriate because, starting in a week, on February 18th, providers with EHRs have to be able to provide individuals with copies of their data, and not necessarily just in summary format, electronically when they request it. Now there is not, there's no change in the current HIPAA rules to the timeframe for that, which is now potentially as long as 30 days, although the regulators could change that. But that's, you know, I would not be happy with substituting the right to get your – you know, we're not necessarily following the law there if we say that the right to a copy of your data is the right to get a clinical summary.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. But … take that away. That should still be there because it's already law, and it would be, I think, the discussion we just had. We would like to get them an electronic copy sooner because that's what we need to coordinate care with. And wouldn't those two be the same thing then? Get the care summary out there within a shorter period of time so that it's supportive of transitions of care, not 30 days.

Eva Powell – National Partnership for Women & Families – Director IT
This is Eva. I think an important difference here too between the clinical summary and the one that we just finished talking about is the fact that from a patient self-management standpoint, it should be provided before that person walks out the door. To the degree that summary has key information and instructions on it, because 48 hours even for a treatment plan or whatever that requires medication to be taken later that evening is not sufficient.

From the patient perspective, there are kind of two scenarios where they need information. One is within the context of the visit because there may be key things that they need to be doing at home … patient engagement based on the content of that visit that they're not going to remember just through a verbal conversation or a shout out as the physician runs out the door or whatever. They're going to need something, access to some information to help them remember that when they get home.

And then the second scenario is, if they're at home, and they need access to information that maybe wasn't available at the visit, such as labs or other test results, and then again, some historical information that may help them understand their visit in the context of their larger healthcare. What's important to retain here is an element of capturing that visit and the key information that's important for that person at home.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think it's my fault for raising it. This is something we suggested before, so let's just accept it in the NPRM is for all the reasons that Eva just brought up.

I want to make sure we have enough time to review the rest of the draft of the letter. Let's go up to page one. I'll try to go through this. As I was reviewing this with the other cochairs just earlier today, the overarching theme we had was we revisited some of the things that were taken out in the NPRM compared to our recommendations. After thoughtful consideration, it looked like we still had strong feelings about some of these specific things that I'll be mentioning. That's sort of the overarching thing.

The first recommendation talked about reinstating the progress note, and I think we both addressed the rationale for them taking it out, and reiterated our strong belief that this contributes to the quality care, to care coordination, and to the use and meaningful use of EHRs. That was the basis for us recommending putting it back in.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Any problems? Okay. Number two, there are a couple versions of this. Let me try to recap our discussion. We came up with a set of attributes of what we thought would be a core measure and remembering that we actually recommended or suggested the concept in the beginning and gave some examples. Once we looked, the examples changed in the NPRM.

Once we relooked at our criteria, we found that the core measures that were proposed didn't meet all the criteria or even most of them. One of the key things that it didn't meet is, well, is this applicable to absolutely everyone? We really couldn't agree with that, say that was true. The other pieces are two of the three, the smoking inquiry and the blood pressure documentation sounded much more like, well, they are process measures, and our goal was to go towards outcomes oriented measures.

For a number of reasons, our recommendation was that none of the three that are proposed seemed like they would be core measures, as we defined them. What we wanted to do is maintain the concept that there are national health priorities that we wanted to – we threw out the various criteria, and we'd reexamined that. And so we said we'd reexamine that and try to describe that more thoroughly in our stage two and three recommendations. Does that capture your recollection of our discussion?

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Does the recommendation, version one, capture that? The recommendation is to remove the core measures from stage one for the reasons that we provide, and that we'll relook at the notion of focusing on whatever, you know, these common health priorities in future stages.

Neil Calman - Institute for Family Health - President & Cofounder
I think that there was another part of this. Is that just approach one that you just--?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Approach two … a bit more wordy, and may confuse things. I think it relates to definitions, so core measures, they way we originally defined it is it applies to everyone. I don't know that we're – well, anyway, why don't I just let you read that, and feel free to discuss.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, while people are reading, could we use a different word than core?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Who is speaking?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
This is Charlene.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think that's the major thrust behind approach one is to try to remove the word "core".

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Yes. It translates, when we think of core measures, we think of the measures we have to report in the hospital.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
In the hospital, right.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Right. So if there was exemplar, your measures, I mean, all those other words people are using out there, but that would just be helpful if you're going to make a change. That's all.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think, Charlene, that's the difference between two approaches, at least that's my perspective of the difference.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Josh, did you…? Who was going to speak? Was that Neil?

Neil Calman - Institute for Family Health - President & Cofounder
Yes. I was going to say something. But, Josh, did you want to say something?

Josh Seidman – ONC
No. I was just – I think that there was – in the last call, there were some workgroup members had expressed interest in trying to be clear about the support for the concept, but also wanting to be clear that these weren't the right measures. I think that that was what the challenge was and trying to express that.

Neil Calman - Institute for Family Health - President & Cofounder
This is Neil. The way that I would summarize this is that we believe that there are some underlying public health, critical public health issues that these initiatives need to address. I don't feel like we just have the wrong measures or whatever. I don't think we're going to find a measure that is applicable to everybody from birth to death and in every situation. I think that's what we found out even when we sort of gave it our best shot.

So I think, rather than say we don't have one, but there might be one at some point. I think what we really want to call out are the public health priorities and the importance of aligning as many of the existing measures as we've proposed, as have been proposed, with those national priorities, and the continued development of measures that would support those priorities, period. From my perspective, that's what we were saying, not that we were somehow just couldn't find the right ones or that our definition of them was wrong.

To restate it more clearly, basically to call out that there are national health priorities that we recognize, and that we were going to call out, and I might have even suggested that we sort of asterisk them or whatever, those measures that are being proposed that directly impact on those national public health priorities, and that continued to develop measures that reflect those priorities as the phases develop.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

I think that's right, and I think what I can do is add that additional wording to say, I think our recommendation is still to remove the core measures from stage one, as proposed, and just give a bit more of an understanding, like what you said in my opening preamble to this discussion.

Neil Calman - Institute for Family Health - President & Cofounder
Yes. I just think I would change the recommendation 2.1. I don't think we're eliminating them because they don't meet the key criteria of a core measure because that makes it sound like if we only sort of had the right ones, we could have done it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'm looking at approach one, which doesn't have that kind of wording.

Neil Calman - Institute for Family Health - President & Cofounder
Approach one, the recommendation 2.0.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
2.0, yes.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It starts, and I think I would embellish the first sentence, which is, focus on the health priorities. We would like to, now and in the future, work towards outcomes oriented measures, and that we're re-explore it in later stages.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Can we state something along the line that Neil said where we asterisk some inside of the specialty specific measures?

Neil Calman - Institute for Family Health - President & Cofounder
I think, to call out the three things that were originally proposed, or even add, I think we were adding obesity, to call out those public health issues, you know, that critical amongst those issues are smoking, hypertension, obesity, and drug safety. And that they're highlighted in the current recommendations, and will be further developed in future stages.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Yes. I like that too, Paul, and I like the wording of, in the second approach for recommendation 2.0 more than I do the way that it's kind of written above there where it just says remove core measures.

Neil Calman - Institute for Family Health - President & Cofounder
Yes. I don't want – what I'm hoping we don't lose in this phase is the necessity of the alignment of the measures with these major public health issues, just because we can't find a measure that's relevant to everybody. We still want to call out those public health issues. I think that's critical in this stage.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Once you start asterisking something, we always have the problem of, and then what about the others. Let me just share with you something we're doing in the strategic planning workgroup, which is to say we need to find, as part of our recommendation to ONC, that there be a way, and we talked about whether it's collaborate or identify or endorse, national health priorities that are particularly amenable to HIT

strategies to improve upon. I think that's the horse before the cart to say, let's figure out what national priorities to pick on. Then have the measures follow those. Right now, we don't have the first piece done. And so that's why I'm a little hesitant of saying asterisk something, which then unasterisk other, and that's the problem.

Neil Calman - Institute for Family Health - President & Cofounder
From my perspective, that could be a little bit backwards from the way I see the world, but not where it's probably worth arguing about. But the way I see the world is, you have a set of public health priorities, and you have a tool, and you use that tool the best way you can to address those priorities. But it sounds like the way you're proposing it is you sort of decide that HIT is a tool, and to look at the things that HIT can best address.

I'm not sure that they're that different, but I think they're different enough that they're probably worth some future discussion. Maybe it's not in this group, but it's probably in your group, in your strategic plan group. There may not be a lot you can do with HIT to address the problem of obesity, but that's an exploration that we shouldn't lose just because we can't think about that just because we don't have proven methods now to think about how that might help.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I actually think that there can be with obesity, but there's no evidence about it. We actually just wrote a big grant about this. But some of the others, we do know that … advance the ball.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right. The way we would accommodate both of those is, one, let's do the things that we know work, and also then let's do the research on how to make … if and how HIT can play a role in some of these other ones where it hasn't been demonstrated yet. Do you see how that's cake and icing?

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's part of the strategic plan recommendation draft as it exists that we're working on. I think that would accommodate your concern and try to avoid the cart/horse thing.

Neil Calman - Institute for Family Health - President & Cofounder
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll work on some wording to try to capture that better. Okay. Recommendation three is to recommend that we actually put back in the stratify the quality reports by disparity variables. Four is the up-to-date issue, recommending that we make it up-to-date rather than just present. It is challenging.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No question about that, but it's sort of not much use if it isn't up-to-date. Five is to reinstate the advanced directives. Our thought was that in fact it does apply to most of the patients for which this incentive program applies.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Neil Calman - Institute for Family Health - President & Cofounder
Another part of our rationale for that was that it is one of the things that sort of stimulates engagement of providers with patients in terms of a discussion.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I think this makes sense.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Six is to reinstate the patient specific education, and it's possible that where we had the most difficulty is they not understanding necessarily what we had meant. So we tried to talk about what are the benefits, and I'm not sure we did explain.

One of their pushbacks was, well, can you really make it fit everybody's health literacy and every condition, etc. But I think our intent was, let's get started, and even if you don't cover all the problems in all the health literacy, we need to start addressing these problems using information from the EHR.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Charlene, you had some comments….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. If we go with this 3/1/1 thing, I think some of that would fall out. This was one that's best done if we know what the problem is. It's really hard in this phase to capture problems in hospitals. Also, we don't have nursing documentation in place, which this is a nursing process, not typically a physician process. So it doesn't work. It's really hard to do in hospitals.

However, if we can go with that 3/1/1 thing, I think what might thought was, you want to say the right thing in the objective. You don't want to lower the bar so much that they do the wrong thing. So those people that can do it, it's great. But give some flexibility, so that's the feedback we're getting. This is hard in many settings. It's costly, but if there's flexibility on doing it, then those things would probably fall into phase two, or some would do it.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes. I'm strongly in favor of getting started with it. It is hard to always have the diagnosis right and so on. There are a lot of materials that are available today.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. Maybe I would back off to make it less patient contact specific to get it going, you know, because then that's the hard, that's the one they struggled with in the near term. So I'm actually in favor of patient contact specific, but at least giving them something, you know, would engage the process. I was actually in favor of the more stringent requirement, but I could back off on that, which would make it easier in the near term, if you want to keep it there.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

I go back to, I can't believe that if we're trying to reduce readmissions, we cannot hand people patient specific information … so I'm sort of stuck there.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, but you know how they do it today, Paul. They pull it from the file cabinet, and it's patient – you go in and you have open-heart surgery or whatever, you have your care plan. It's on the wall when you're there. And when you go home, here's that list of things that you do when you go home. You take it with you and all those things.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I understand, but they can do that through the electronic accounts record as well.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, if they have care planning and clinical documentation and all those functions up, you know.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, that's not required because you can choose from the list of things about the operation or about the heart failure, and click on it within the EHR, and have that produced.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, the nurse can, right? They do the discharge process.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's not prohibited here.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
No, I'm just saying all those other things to support the nursing is coming later. Anyway, I mean, I think if we get the flexibility of 3/1/1, then those things would be deferred, and the only thing would be to lower the bar just a bit to make it easier in stage one, which is not make it so patient contact specific, because there are all those sources out there, the electronic sources out there today.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Where are people on the patient specific education?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
That doesn't seem so hard to me.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
What they do today is they can get it, like, from MedLine and all those sources, and they go and the find it exactly. They click it, they find it, and they print it, and they make it available, so it's an extra step, and it's somewhat onerous, but that's kind of what they do today. But it is not integrated with the relevant stuff from the EHR.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
We aren't saying that it has to be integrated, are we?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That's patient content specific.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Okay. The wording that we have is EPs and hospitals should report on … for which they use the EHR to suggest patient specific education resources.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, that's the trick.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Do they have to really use the EHR?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Why couldn't they use Google?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What's accomplished there?

Neil Calman - Institute for Family Health - President & Cofounder
Google is not going to know if it's patient specific.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
But the nurse knows what the diagnosis is.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, the nurse knows. They'll have their process in place to do it.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But then there's no EHR, so why would that be meaningful use of an EHR?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. It's just harder to do what you want, and we'd leave it at that, and if it's optional if they do it, the intent is there, right, and they move. It's just it'll be harder to do. But you want it electronic without a specific. Again, you'll know the diagnosis. You'll go in and do it. Some EHRs will have it there. Others won't. It'll be part of their system.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Charlene is accepting it because of the flexibility. What do other people think?

Neil Calman - Institute for Family Health - President & Cofounder
I agree. This is Neil.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
David?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes, I'm okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Art?

Art Davidson - Public Health Informatics at Denver Public Health – Director
Yes, I think I'm okay. I'm now kind of questioning what Dave was bringing in about if they use Google versus they have to have the EHR use Google. Is that what we're saying?

Deven McGraw - Center for Democracy & Technology – Director
No.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, we didn't say how the EHR does it, but you have to use information. You use the EHR to suggest, so it does, and the reason it's worded that way is because of the meaningful use of EHR.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Art Davidson - Public Health Informatics at Denver Public Health – Director
So does that mean that if look up the problem list that exist for this patient in the EHR and then go use Google, it's okay?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I don't know. I wouldn't read that … because it says to use the EHR to suggest, so I would say Google based on your human information is not the intent here. Does that disturb anybody's opinion?

Neil Calman - Institute for Family Health - President & Cofounder
No.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Recommendation seven is to, well, to suggest reinstating the efficiency measures that we had such as the generic when those options exist, and the … require that at least one of the five deal with efficient diagnostic test ordering. Any objections to that?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Do we know why they were dropped?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

We don't. Is there, Tony or anyone, give us a little insight into why it was dropped? Is Tony still on or anybody from CMS?

Neil Calman - Institute for Family Health - President & Cofounder
I have a question about this though. There's 29 proposed clinical quality measures for primary care physicians in the NPRM or something like that.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
My understanding is that all those tables, they were trying to get comments on how to whittle them down to three to five.

Neil Calman - Institute for Family Health - President & Cofounder
Well, there are a number of them in the primary care measures that are relevant to efficiency. There's treatment for children with upper respiratory infection, avoidance of inappropriate use of antibiotics. There's another one on appropriate antibiotic use for ear infections. Those are two in specific that are clearly related to efficiency.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The concept of the rule was then you would be prompted for that in your workflow that you did those things. So it would correspond to your measure, so that would actually be good.

Neil Calman - Institute for Family Health - President & Cofounder
I'm not sure I followed that comment.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Give me one of the examples of the efficiency measure.

Neil Calman - Institute for Family Health - President & Cofounder
Appropriate prescription of antibiotics in children with upper respiratory infections.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
There'd be a rule that says, okay, this child has an infection. And, if so, if you entered one that wasn't appropriate, it would signal you back that that was an inappropriate one. That would be the clinical decision support. Now again, it's not a diagnostic imaging study.

Neil Calman - Institute for Family Health - President & Cofounder
I guess when it says, "Reinstate the recommendation to include measures," maybe – it says CMS did not include any measures of efficiency. I'm not sure that I wouldn't count those as a measure of efficiency.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. I agree with that. That statement is not accurate.

Neil Calman - Institute for Family Health - President & Cofounder
Right. In the letter, I would prefer to say that somehow there should be some measures of efficiency that are included in required, you know, in our required measurers. Maybe this goes back to George's 3/1/1 business that there should be at least one measure of efficiency that's included in what people are going to report on.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Actually, given the fact that eRx is a ubiquitous requirement, that's how generic would be fit that. That's why that could be a required one, following your paradigm.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It would be nice if we knew why that was taken out. I suppose we can try to get it back in.

Neil Calman - Institute for Family Health - President & Cofounder
Why what was taken out?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
The efficiency.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This whole generic.

Neil Calman - Institute for Family Health - President & Cofounder
Oh.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Do we want to still recommend that the … go one at a time, that the generic efficiency measure be put back in, and I'll reword the recommendation to capture this required concept.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Paul, do we know how much of a problem that is? It sure seems like there's a lot of work to make sure everyone takes generic. Is this a huge one?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I mean, there's a lot of money at stake. It varies enormously actually from site-to-site how much there is. In many states, there are substitution laws, so it's not really a very big problem.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, and California is one of those states where the pharmacist, by default, are, one, allowed, and two, I think, almost required to substitute. We actually went broader than that. We talked about generic where that exists in the drug class, which is a very different thing.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
That's quite different.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's quite different, and that, you know what, it didn't get captured … generic … yes, it did. When generic options exist in the relevant drug class, so that's a big one. I think it's big, both on a clinical and financial basis.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
You know if like the drug files do that now? I don't even know that. You know, like the clinical decision support.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Sure. You mean in clinical systems?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes, like the First DataBank and all those things, they do that now?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I don't know that First DataBank has a module for that actually.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Neither does MetaSpan.

Neil Calman - Institute for Family Health - President & Cofounder
…has to be developed.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think that comes with SureScripts. Well, it's either the old SureScripts or the RxHub, but there are times when it comes back that way.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It sounds like it's where you want to signal, anyway.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Actually our recommendations, as were all of our past recommendations, this was reporting only and not a threshold.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
We have this in place for 100% of our prescriptions, and it's one of the places that you get the biggest savings. I think it's important to send a signal.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Are we still good with 7.0? How do we feel with 7.1, which is at least one having to deal with the efficient diagnostic test ordering, one of the CDS's?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think people aren't going to know what that means.

Neil Calman - Institute for Family Health - President & Cofounder

Could we say test ordering or prescription, I mean, or treatment stuff so that we could include those others as potential ways of meeting this?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What was the or?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I would rather have it be testing. It could just be something about a redundant test. There are a ton of things that every system should have in.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
That would actually be powerful.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's not going to be possible though without some sort of exchange because the redundancy is most of the time, I think, between providers, not within a provider setting.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Actually, there's plenty of redundancy within providers. There's lots of provider redundancy.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
What David just explained, we wouldn't even have interpreted that. We would have thought of these imaging tests or something, so that's why I think people aren't going to know what it means, but I think that redundancy issue is important.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Maybe we should supply an example with it….

Art Davidson - Public Health Informatics at Denver Public Health – Director
We started with the high cost imaging services. That was the one that was in the original matrix.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
For imaging, it's a little more complicated. In fact, the evidence about this is much more mixed.

Neil Calman - Institute for Family Health - President & Cofounder
Is there really a way that a system can determine whether something is duplicative?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Sure.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
How does it know that you're not doing serial MRIs because of an evolving condition, as opposed to repeating an MRI?

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine

It actually doesn't know that, and it lets you go ahead, but it just points out to you that there was another one, so that if you want to go ahead and do it, you can. But it just says that there is this other one. Did you know that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
It's within timeframes, and that's its only cue.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

Neil Calman - Institute for Family Health - President & Cofounder
You'd get a lot of unnecessary reminders.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
But sometimes, like the system support, recurring ordering, and that, you'd set that up as a recurring order, so that wouldn't get checked, but there are other times when it's lab tests or you have someone come into the ED, and then you put them up on the floor, and you don't have the data or something, because it picks up some of that stuff.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me get a thumbs up, thumbs down on recommendation 7.1, yes or no?

Neil Calman - Institute for Family Health - President & Cofounder
No.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I'm going to say yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So we have one yes, one no.

Neil Calman - Institute for Family Health - President & Cofounder
I would make it more generic. I mean, no because I'd make it more generic. Not just say efficient test ordering, but address some efficiencies in diagnostic ordering or treatment.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think it would be good to say, reduce duplicate testing because you're telling them something then. I mean, that's one of the things that seemed like was part of the cost savings that was coming out of ARRA was reduction of redundant testing.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Definitely.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
So that amendment is accepted by David. How about Neil? That's not an amendment. It's a different … opposing….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It's an example.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Can you restate that, please?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think Charlene said, have one of the decision support rules address duplicate testing, period. Is that true, Charlene?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I think you need it framed in efficiency, and then, as an example, use that as an example.

Neil Calman - Institute for Family Health - President & Cofounder
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's going back to what Neil said, so broaden it to efficiency and give examples.

Neil Calman - Institute for Family Health - President & Cofounder
Yes.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Then broadening to efficiency could be, we leave in as well therapeutic decisions.

Neil Calman - Institute for Family Health - President & Cofounder
Exactly. That's my point.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
We have a drug one up above. That's why I would like to stay a little narrower with something related to testing.

Neil Calman - Institute for Family Health - President & Cofounder
But the drug one is about a drug class. It's not about appropriate use of medications.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Yes. You're going to have to have some test things pretty soon.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let's see. I think we have Art. Someone has to render an opinion on testing versus overall efficiency.

Neil Calman - Institute for Family Health - President & Cofounder
I think we should allow the practices to basically decide where they think there's the biggest bang for their buck. If you're a pediatric practice … hardly does any testing, I'm sure appropriate antibiotic use has a lot more bang for the buck than duplicate testing does.

Art Davidson - Public Health Informatics at Denver Public Health – Director

I agree with Neil.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's two for broader efficiency. Charlene?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I'm okay with broader with the examples.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Who else is on the call from the workgroup?

Deven McGraw - Center for Democracy & Technology – Director
Deven. I'm okay as well.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. We'll go broader, and we can list examples such as redundant testing.

Neil Calman - Institute for Family Health - President & Cofounder
Right, inappropriate antibiotic use, list a few of those.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Eight is basically sort of recommendation. In the NPRM, there was a thought, and I think I have this correct, that they published the criteria, let's say, for 2013 by April of, I think it was, 2012. The thrust of this recommendation is to try to give everyone much more of a longer lead time, a heads up in terms of what the future stage criteria would be.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
This seems attractive to me. Charlene, wouldn't you like to know this?

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. This is, I think, the biggest – the timetable is the biggest issue for the community. This is like our number one issue. And even if you move it up, like we typically need an 18 month glide window to get the new stuff in, so the sooner you could signal, like we need to be doing stage two now, so we would like stage one and stage two merged, frankly, so we could work on it now.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Our timeline for this workgroup is to actually work on stage two in 2010, and even by somewhere in the mid 2010 to try to come up with some at least signals. I don't really know how to word this, but signals about updates to our placeholders in 2013 and stage two.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
It couldn't be soon enough, frankly, is our only point. We would really like to get, you know, I mean, hopefully it's not going to add much onto that list because we need to be working on that. You know, those things have to be in the pipeline.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

Recommendation nine is just a clarification, and it's ambiguous at best, that CPOE. Our intent was that CPOE would be done by the ordering provider, not just any licensed professional, i.e. to try to avoid the verbal order problem.

David Bates - Brigham and Women's Hospital - Chief, Div. Internal Medicine
I agree.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. We have five minutes. How is this looking overall? As I said, as I was presenting a summary, it's basically reinstating a lot of the things after a few reconsideration that we thought were important. And then I think we did make a major breakthrough in the sense of saying, and on top of that, we'll offer some flexibility.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Yes. I guess, if you're going to do the 3/1/1, then it would be, look at your cumulative of everything you've put back in because, again, it's cumulative count of doing everything that gets overwhelming, not necessarily each item by itself, but it's the cumulative nature. If we add it all back in, then do we add up with 30 rather than so does the 80% dropped in, so that has to be thought through a bit.

Neil Calman - Institute for Family Health - President & Cofounder
Can I just raise a question that I didn't send you an e-mail? You can just tell me if it's irrelevant to us.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Sure.

Neil Calman - Institute for Family Health - President & Cofounder
That is how the providers are going to define themselves in terms of which sets of criteria are, not relevant, applied to them? For example, assuming there's going to be a subset of these quality criteria developed, and if you're a pediatrician, there's going to be one potential set, if you're an internist another, but if you're a family doc, which ones do you choose? And if you're a cardiologist that also does general internal medicine, like a lot of people do, are you a primary care doc, or are you a cardiologist? And which set of criteria do you choose? Are you required to do both sets if you're in family medicine, or do you pick one? This is just a question that came up, and maybe there's an answer to it already. But if there's not, it's something that might need some clarification.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here's my interpretation. One is internal medicine versus adult medicine would fall under primary care, and there's just a big table for primary care. And I think the intent of having these tables is to say, look, we can't predict what applies to your practice, but pick one table and choose from it. And then the further obligation, then whatever you choose, you'll have to report in stage two, or I think it's the second year, the next year, because presumably they want to find some kind of improvement tracking.

Neil Calman - Institute for Family Health - President & Cofounder
For people in family medicine, they would either pick the adult or the…?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Whatever table they would like.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Paul, I know this is one I haven't sent in either. This is on this whole measure space. It's like this is so brand new to automate this to the hospitals is really, I don't know. We can barely evaluate it in the time window, let alone respond in a positive way, so it's a challenge on the hospital side to do this because of the ramp up.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes. If Tony is still around, maybe comment. We discussed this at our face-to-face, the whole 35 measures thing. I don't know what the answer to that is….

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
I … recommend to you. On the one hand we think, by law, we have to report something. But we're trying to find something we can recommend.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, I think we did a great job. Thank you, again, for being able to respond on all these short notices, so hopefully we'll get some additional feedback from the committee. Do we already have another workgroup call scheduled, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Let me check, but meanwhile, we do need to get some comment from the public, don't forget.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Sorry. Okay. Operator, are there any comments from the public?

Operator
(Directions given.)

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul, the next meaningful use workgroup call is March 4th, 10:00 to noon eastern time.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We're going to need one between now and, well, like within a week to ten days of our meeting, and the reason is because we have to finalize the letter that's due March 1st.

Operator
We have one member of the public with a comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
If that person could please identify themselves, their name and the organization, and keep your comment to three minutes or less. Thank you.

Allison Viola – AHIMA – Director of Federal Regulations
Good afternoon. This is Allison Viola from AHIMA. Thank you for the opportunity to comment. I wish I was able to jump in about an hour ago when you were discussing the medical record response period. It is 30 days with an additional 30-day delay given the purpose for that. Many times states reduce that time limit to, it could be about 15 days. And, in turn, many organizations or facilities even reduce that response period and their internal policies to meet patients' record requests as well. Thank you for the opportunity to comment.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs

Thanks, Allison. That's helpful.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What was 30 days again? Thirty days was the time limit?

Allison Viola – AHIMA – Director of Federal Regulations
The 30 days is a HIPAA requirement. I think Deven brought that up earlier.

Deven McGraw - Center for Democracy & Technology – Director
I did.

Allison Viola – AHIMA – Director of Federal Regulations
But you do have the opportunity to extend for an additional 30 days, but you have to let the patient know. And it's also governed by state laws, if they want to reduce that timeframe less than 30 days.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Is there a requirement they can provide it in electronic format or any requirement at all?

Allison Viola – AHIMA – Director of Federal Regulations
No, I don't believe so, just governed by the HIPAA or the state laws.

Deven McGraw - Center for Democracy & Technology – Director
Right. There may be some state law requirements with respect to electronic records, but Allison is exactly right. What happened in the HITECH Act was just a sort of stronger underscoring that the record copy that goes to the patient has to be electronic when the patient requests it, and you're dealing with an electronic health record. But Congress didn't touch the existing timeframes in HIPAA of 30 days or more. But they certainly could because that's within … OCR could make that change, and we certainly have the ability to layer on top of that from a meaningful use perspective if we wanted to.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's helpful. We already tightened it up tremendously.

Allison Viola – AHIMA – Director of Federal Regulations
I hope that was helpful, but again, feel free to reach out to us if you need some clarification.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks, Allison.

Allison Viola – AHIMA – Director of Federal Regulations
Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Any more public comment?

Operator
No, we do not have any more members of the public on the line.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thank you. And so, for the workgroup, we are going to have to schedule some more time and probably two to three hours between now and seven or ten days after our committee meeting, unless there are no further comments from the committee. Is that okay?

Neil Calman - Institute for Family Health - President & Cofounder
Thank you.

Art Davidson - Public Health Informatics at Denver Public Health – Director
Thank you, Paul.

Charlene Underwood - Siemens Medical - Director, Gov. & Industry Affairs
Thank you.

Deven McGraw - Center for Democracy & Technology – Director
Thank you.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Thanks, everyone.